JUVENILE FORENSIC SERVICES INVOICE

Community Mental Health Center **Center #** **Month** **Year**

	Name of Service Recipient	Socical Security Number	Date of Evaluation	Comprehensive or Screening Evaluation (C or S)	Service Provided (1-6)	Amount Billed	Amount Approved for Payment by TDMHDD (For TDMHDD use only)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
					TOTAL THIS PAGE		

Name of Person Submitting Claim (Please Print) **Date** **Phone Number**

Name of Forensic Coordinator

TDMHDD Forensic Services Approval **Date**

1=Competency Only
2=Insanity Only
3=Both Competency & Insanity
4= Evaluation (Diagnosis, Treatment and Service Recommendations
5=Psychosexual
6=Other